VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

July 6, 2012

Ms. Judy Morton, Administrator
Mountain View Center Genesis Healthcare
9 Haywood Avenue
Rutland, VT 05701

Provider #: 475012

Dear Ms. Morton:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **June 6, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475012	A. BUILDING _____ B. WING _____	C 06/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW CENTER GENESIS HEALTHCARE	9 HAYWOOD AVENUE RUTLAND, VT 05701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 06/06/12. The following is a regulatory finding.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to use its reporting system to assure a safe environment as is possible for 1 applicable resident during a resident to resident interaction. (between Residents #1 & #2) Findings include: Per record review on 06/06/12 Resident #1 and Resident #2 live on the Dementia unit, both with a diagnosis of dementia and impaired cognition. Resident #1 is bed-bound, has an indwelling catheter and has a half-door to prevent wandering residents from entering the room. Resident #2 has a history of wandering, rummaging and has a fixation for cords. Per the care plan for Resident #2, staff are to monitor wandering behaviors in other residents' rooms, close half-doors and monitor close observation. Per review of incident report dated 05/19/12 at 9:00 PM, and a nursing progress note on	F 323	The Center's filing of this plan of correction does not constitute an admission to any of the alleged citations set forth in this statement of deficiency. The Center files this plan of correction as evidence of the Center's continued compliance with all applicable federal and state laws and regulations. An incident report and nurses note was completed for Resident #1. 6/6/12 To ensure no other residents were affected, incident reports were audited to ensure incident reports were completed for both parties for resident to resident altercations. 6/6/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Morton — TITLE: Administrator — (X6) DATE: 7/2/12

' deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ir safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PWL

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F 323	Continued From page 1 05/20/12 for Resident #2 states - "resident (#2) walking down hallways with Foley cath and tubing in right hand balloon inflated...". The family and doctor for Resident #2 were notified of the incident two days later. Per review of Resident #1's chart, there is no documentation pertaining to the resident's catheter being pulled out suddenly by Resident #2, nor is there an incident report, which is used to evaluate and analyze hazard and risks. In addition, there is no documentation as to what treatment, care or interventions were given to Resident #1. Per interview on 06/06/12 at 2:00 PM. the Director of Nursing stated that s/he was not aware that Resident #1's half-door was closed, the whereabouts of staff or Resident #2, and what interventions were provided to either resident on the evening of 05/19/12. S/he would expect this information to be noted on an incident report or further documentation in the resident's chart. The Administrator confirmed that the facility failed to use its reporting system to assure as safe an environment as possible.	F 323	Education for licensed nursing staff will be conducted regarding accurate completion of incident reports for resident to resident altercations. Nurse Managers will monitor for completion, and report findings to CQI committee monthly for 3 months. F323 POC accepted 7/3/12 SEmmons RN/ PMC	7/20/12